

Working with families

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A family doctor who works with families should 'think systems'. He or she will still see individuals in the surgery 95% of the time, but in the back of his mind will be questions such as 'What's been going on in this person's family that might be related to these symptoms or illness?', 'Does this chronic illness play a role in the family set-up which may make for resistance to treatment?', 'What would have to change if this person suddenly got better?' The term 'tertiary gain' has been coined by Dansak (1973) to describe the pay-off of a symptom to the family unit or social system as a whole.

Certain situations indicate the need for a family assessment, particularly if the doctor has not already met the family. (A family orientation is much easier if the doctor usually cares for the whole family and makes a practice of doing the initial health history with the family as a unit – a time-saving and more accurate method than 5 or 6 individual interviews.) Indications for a family interview include: several visits for minor symptoms by one or more family members in a short time span; difficulty in management of chronic illness; diseases related to lifestyle and environment (alcoholism, chronic obstructive lung disease with cigarette abuse, peptic ulcer); poor compliance; the diagnosis of a serious or terminal illness; an unexpected death; before, during and after an expected death; emotional, behavioural or relationship problems; critical periods in the family life cycle (e.g., pre-natal, pre-retirement); and genetic counselling.

A great deal of family information is derived from the individual visit. If the doctor has once observed the family together, he or she can 'read between the lines' of a patient's statements and symptoms. If the doctor 'thinks systems' he will automatically see them in context and be aware of when he needs to see family members in person, rather than, as one person put it, 'seeing them sitting invisibly around the patient in his office'. In medicine diagnosis precedes treatment. Similarly, family assessment is essential to an effective intervention, such as patient education, anticipatory guidance or facilitation of communication, which may be the goal of the interview. For

example, if Granny is in charge of the kitchen, she may be essential to a discussion of the diabetic control of her grandchild; if Aunt Mildred is the family medical authority, her approval of you and your treatment plan may markedly improve compliance.

Time is always an issue for a doctor. Where can one find time in a busy practice for family interviews? Many practitioners find it best to set aside half a day a week for counselling sessions with individuals and families of 20 to 30 minutes each. Others reserve the last hour of one or two afternoons to see families. Up to 3 sessions with a family a week or month apart can be very effective if the problem is picked up early. More than 3 suggests a need for referral.

Many effective interventions take very little time. Examples are the simple questions: 'Have you thought about how you'll spend your time and feel useful in 5 years when you retire?', or, 'Have you thought of next year when Johnny is at school all day?', or the statements: 'Many fathers feel left out or jealous when the new baby arrives. It's important to spend time together as a couple or you'll gradually lose the good communication I see you have now', 'How about taking Jane in to see around the hospital before she's admitted for the operation?' Asking that the spouse of a non-compliant hypertensive patient come in next visit, or bringing in the relative sitting in the waiting room, will increase the information base and the family cooperation but will not take up more time.

If the doctor already knows all family members, asking them to come in together will be easy. They will already feel he or she understands them and is on their side. (The task of siding with every member, the villain as well as the victim, comes from a systems approach. If in a given family one finds oneself hopelessly aligned for or against one member, there is danger of aiding or increasing family dysfunction, and one should refer them elsewhere if possible.) If all members are not known prior to the interview, a few minutes 'joining' with each person is necessary. This is particularly true of children who are often ignored in a family meeting in contrast to a paediatric visit. Yet they are a valuable source of family information,

particularly if their non-verbal messages are heeded. If children feel redundant, boredom and distracting behaviour will be the result. If behaviour problems are the reason for seeing the family, observing what precipitates them in the office (e.g. when mother and father start to argue) and who attempts discipline and how, can often give more information than asking *about* behaviour at home. When a 10-year-old blows your blood pressure cuff up to 300 mmHg it is important to set limits (role-modelling, as well as self-preservation), but it is usually best to request that the parents exert the discipline rather than taking over for them – a common mistake.

A *family assessment* usually focuses on the presenting problem (e.g. non-compliance in a chronic illness, behaviour problem in a child, 'conspiracy of silence' around a terminal illness, pending hospitalization of the only breadwinner). For this reason, our family assessment tool with the acronym 'PRACTICE' (see Appendix, p 47) starts with the presenting problem. The form acts as a summary sheet of the main areas dealt with in the family therapy literature: Roles and family structure, Affect or emotional tone and expression, and Communication. The last is the most crucial aspect of assessment: a family that communicates clearly, directly and openly, and expresses affection as well as anger and sadness, will rarely be dysfunctional and will solve the problems life presents. Illness-prone families (families with all the Ds – disease, early death, dysfunction, divorce, delinquency) communicate indirectly, often with fixed triangulation, and problem-solve poorly (Hinkle & Plummer 1952, Minuchin *et al.* 1975).

The second half of 'PRACTICE' consists of items essential to the family doctor: Time in the life cycle, of which we are the privileged long-term observers; Illness history and attitude to doctors, a major determinant of family expectation and behaviour of family and patient; Coping or strengths, without which we would be ineffectual; and Environment or Ecology, the surrounding systems of culture, work, school, religion, social services, etc., which can stress or help the family. The ability of people to cope, grow and heal themselves is crucial: the family doctor's ability to focus on positive attributes and to facilitate communication and growth, despite or because of pain and illness, is essential to his or her role as healer. A more detailed description of 'PRACTICE' is found in the book 'Working with the Family in Primary Care' (Christie-Seely 1984).

Like a functional enquiry or systems review, one or two aspects of assessment may be more relevant for a given problem, e.g. roles and structure when the mother requires hospitalization; affect, communication and illness history during terminal

illness. The form is a convenient way of recording impressions from an interview and a reminder of what to look for, but should be completed as a summary after the interview. Another very useful visual record is the genogram (more correctly 'phenogram') or family tree, a brief form of which is as quick as a written family history (see Tomson, p 34). New information can be added later. A genogram can show conflictual relationships, fixed triangles, repeat family patterns (e.g. an asterisk can indicate shotgun weddings and children out of wedlock in a family whose teenager presents with pregnancy) and family cut-offs and labels; as well as illness history with dates which may indicate clustering of events and illnesses (e.g. after a death).

Skills required for working with the family

Working with the family implies working with the system, as it is, for improved health care; unlike the family therapist we have neither the mandate nor the skills to change families. However, many of the families we see – in contrast with those seen by marriage counsellors or psychiatrists – are functioning well, although they may be in a crisis caused by illness or environmental stresses or the normal events of the family life-cycle, such as a pending 'empty nest'. For these families, feeding back our diagnostic impression of what is going on in the family may be enough to stimulate them to make their own changes. For instance, in a family where the young mother had breast cancer, no one talked about the illness, but the 12-year-old son was having behaviour problems and the father was drinking excessively. The latter was a repeat of the patient's father's behaviour when her mother died of cancer when the patient was 10. She was very worried that her husband would not cope and that her younger son, also 10, with whom she identified, would suffer as she had as a child. One family interview, done on a home visit, was all that was necessary to 'reframe' (relabel) the problem and change the behaviour. During the interview, whenever any mention was made of the mother's illness, the older son would distract by misbehaving, or the father would mention something the son had done the day before. I commented each time this happened and facilitated family communication and expression of fears and guilt and anger about the illness. They learnt to use Jimmy's behaviour as a barometer of tension and unexpressed feelings, and also recognized that the drinking had a similar function. The idea that 'one marries one's childhood's worst nightmare' helped the mother understand how she was in fact encouraging alcoholic behaviour in her husband and helping to realize her worst fears. An understanding of triangulation and an ability to

observe sequence of interactions was all that was required to give this family a small push in a healthier direction. The visiting nurse was also present, and on subsequent visits helped reinforce what had been said, even though she had no training in family counselling.

Facilitation of communication, particularly when a family is not talking about illness or stress, can have a major and lasting impact. There is evidence that counselling prior to a death can be effective in decreasing the increased morbidity and mortality in the bereaved (Parkes & Brown 1972). The doctor needs skills in stimulating family interaction, for example: 'Most families I know feel they are protecting each other from more hurt if they keep their feelings of sadness to themselves. But then I see them getting ulcers or high blood pressure. If you can share your feelings you'll find it helps a lot to let out some of the tension. Crying together feels better than everyone crying alone in their room - and crying is nature's way of helping a person cope and get over the sadness. What do you think about that? Maybe you could talk about it together.' Pushing one's chair back at this point will help get one out of the usual position of the beginner interview: it will get the family wheel turning with the interviewer facilitating rather than being the hub of the wheel with all spokes or interactions leading to the doctor. The latter keeps the doctor *in* the system and will not help the family when they go home.

Normalization is an important aspect of facilitation. It is a fancy label for a common practice, but labelling can be helpful in emphasizing the value of something we take for granted - reassuring a patient that something is normal. It gives people perspective and permission and removes the stigma of the abnormal. For example: 'It's normal for a man in our culture to think he should keep a stiff upper lip, but crying is a normal response to grief'; 'It's normal for a 2-year-old to have temper tantrums'; 'It's normal for a mother to worry about her first child, but children normally eat less at 1½ years'; 'Women have an even slower sexual response, and men a faster one, when they're anxious'.

Education or information-giving is often much more effective if given to the family rather than the individual patient. Particularly at times of crisis, the ability to take in information is limited. If more people are present, more will be heard and questions from the family can be answered. Information will not suffer the distortions that can occur if passed through an intermediary. For example: 'My doctor says you shouldn't be so lazy about helping with the housework because of my

bad back', or 'Johnny's asthma attacks are because you get angry at me', will not help the home situation or the family support of the doctor-patient relationship. The decision-maker of the family, if not amongst those informed, may discount the information: 'What do you mean he says you have diabetes and he's giving you a diet? What about Uncle Bob who had diabetes and needed insulin and had both his legs off and died at 42? You'd better go to a doctor who knows enough to give you insulin.' Similarly, a triangle can very easily be set up between a mother caring for a child with a chronic illness, and her husband and the doctor.

Information about family functioning can be given to a family without major problems as part of anticipatory guidance or prevention. For example, the six paragraphs reproduced from Papp *et al.* (1973) in my earlier paper on the family system (p 5) were written for 'healthy' families wanting to know more about family dynamics. Giving one's diagnostic impression of how the family's functioning and illness may be interacting is part of education, and is usually better given to the family as a unit.

Anticipatory guidance by a physician is an important part of preventive medicine (Christie-Seely 1981). With a broader perspective of the stresses of the family life-cycle and of illness the doctor can educate patients about what to expect. 'Normative crises' of marriage, birth, school entry, adolescence and mid-life crisis (which tend to coexist), the 'empty nest', retirement, and loss of a spouse are known to be associated with an increased incidence of illness (Huygen 1978, Haley 1973). Illness in one family member often triggers illness in another member through stress (Christie-Seely 1983, Bruhn 1977), sick-role-modelling or mimicry, and competition for attention, as well as through contagion and genetic susceptibility. Ventilation of feelings, discussion of role changes, stimulating 'thinking ahead' to times like retirement, and specific suggestions are all part of anticipatory guidance.

Specific suggestions can also be helpful in many other situations. As distinct from advice giving, in which the physician takes the responsibility for problem-solving away from the patient, specific suggestions broaden the patient's options. They include such things as a description of available community resources, the Sensate Focus programme for helping with many sexual problems (Kaplan 1974), the suggestion to a young mother of an exchange day off with a neighbour who also has small children, and simple instructions to improve communication. For example: 'How about having a "date" with your spouse without

your children for a change – they won't always be around'; 'Try to speak directly about your relationship and not indirectly by using the children or your mother-in-law'; 'Why don't you each take time to repeat what you think the other one is saying to you, in your own words, to make sure you understand, then tell the other how that makes you feel, instead of defending yourself with a counterattack.' These facilitate the process of problem-solving, but do not hand out solutions like: 'I think you two should split up'; 'You should move to another city'; or 'Tell your mother she has cancer, even if your father disapproves', any of which may have unpleasant repercussions for both family and doctor.

Emphasizing family strengths and resources is an essential part of support and facilitation of growth. *Positive reframing or relabelling* helps the family see things in a new light, and see liabilities or problems as assets. For example, the son of the mother with breast cancer was labelled as 'rescuer' protecting people from their feelings, instead of the bad kid who was just like his father; the delinquent child may be seen as the 'family therapist', either because he diverts attention away from parental conflict or takes the family to a professional for help. A husband seen by the wife as neglectful and uncaring because he is always at work can be relabelled as driving up his blood pressure through overwork to help his wife feel financially secure; her nagging can be interpreted as caring for his health and as an expression of her difficulty in telling him directly how much she loves him and wants him around.

Crisis intervention and referral

Sometimes serious family situations arise or chronically dysfunctional families need help. The skills of crisis intervention may be needed until it is possible to refer. Knowledge of one's limits is essential, and too often this is lacking in family doctors who do extensive counselling without training and have never observed family therapy by an expert. Siding with one family member is a particular hazard which can precipitate greater family dysfunction. Severe, chronic or multiple problems should be referred. As with the diagnosis of appendicitis, our mandate is to diagnose and recommend treatment, but not to operate unless sufficiently trained in surgery. Familiarity with the

operating room, the surgeon and the risks and benefits of surgery as well as the chances of a spontaneous cure all contribute to effective referral. So too with family therapy – the family doctor should know the family therapist, who can be of great value as coach in working with families, and the fact that family therapy is successful in 2 of 3 cases, but will probably increase the 'pain' at the beginning when arguments will usually escalate. Referral for individual therapy may be indicated for the member most motivated to change, but runs the risk of labelling that member as the sick one, and of marital breakup if the spouse feels left out or unable to cope with changes in the partner. Referral to community agencies or self-help groups is an equally important area to which the same principles apply.

These skills can be part of any doctor's practice. The family doctor inevitably impacts on the family, just as the family will have an impact on the doctor-patient relationship and on the illness. It is obviously preferable to understand and optimize this doctor-patient-family triangle (Doherty & Baird 1983), for the better health care of the entire family.

References

- Bruhn J G**
(1977) *Journal of Family Practice* 4, 1057
- Christie-Seely J**
(1981) *Canadian Family Physician* 27, 449–455
(1983) *Canadian Family Physician* 29, 533–540
(1984) Working with the Family in Primary Care: A Systems Approach to Health and Illness. Ed. J Christie-Seely. Praeger, New York
- Dansak D A**
(1973) *Comprehensive Psychiatry* 14, 523
- Doherty W & Baird M A**
(1983) Family Therapy and Family Medicine. Guilford Press, New York
- Haley J**
(1973) Uncommon Therapy. The Psychiatric Techniques of Milton J Erickson. Norton, New York
- Hinkle L E jr & Plummer N**
(1952) *Industrial Medicine and Surgery* 21, 363
- Huygen F J A**
(1978) Family Medicine. The Medical Life History of Families. Dekker and Van de Vecht, Netherlands
- Kaplan H**
(1974) The New Sex Therapy. Brunner/Mazel, New York
- Minuchin S, Baker L, Rosman B L et al.**
(1975) *Archives of General Psychiatry* 32, 1031–1038
- Papp P, Silverstein O & Carter E**
(1973) *Family Practice* 12, 197
- Parkes C M & Brown R J**
(1972) *Psychosomatic Medicine* 34, 449